GUILFORD/MADISON RADIOLOGY

MAMMOGRAPHY HISTORY SHEET

Patient's Name_____ Date_____/_____/_____

Date of Birth_____/_____/_____ MRN#_____

Reason for Exam: Routine_____ Other_____

Prior Mammograms:Yes_____,if so, where?_____when?_____

Baseline_____

Outside Films Requested:_____

Radiation Treatment to the Chest or Abdomen:_____

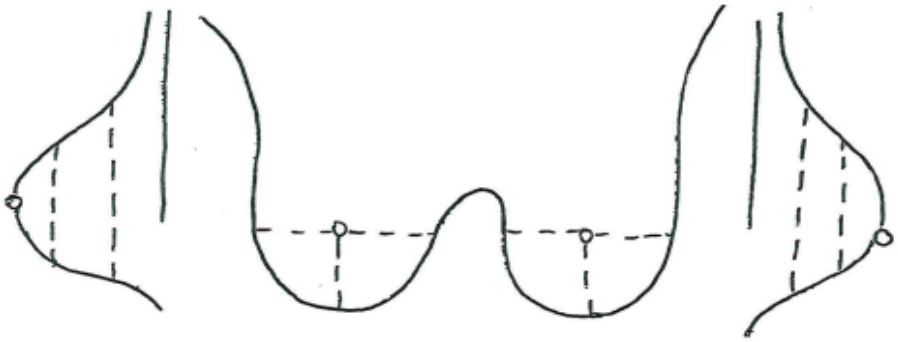
Menopause?_____HRT?_____ How long?_____

	Right	Left	Dates/Comments
Cyst Aspiration	_____	_____	_____
Benign Biopsy	_____	_____	_____
Lumpectomy	_____	_____	_____
Mastectomy	_____	_____	_____
Radiation Therapy	_____	_____	_____
Implants/Reduction	_____	_____	_____

Please note any scars, moles, or masses

Risk Factor

Right Left



Family History of Breast Cancer: (please note approximate age of onset)

____Mother_____ Sister_____ Daughter_____ Other_____

No family history of breast cancer_____ TECH INITIALS_____

COMMENTS_____